WAR MEMORIAL HOSPITAL
WAVERLEY

CLINICAL STRATEGIC PLAN 2018

You're never too old to live life

Uniting

NSW GOVERNMENT Health
South Eastern Sydney
Local Health District

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Table of Contents

Foreword

War Memorial Hospital Waverley (WMH) is a unique healthcare service within Uniting, offering specialist aged rehabilitation within the South Eastern Sydney Local Health District (SESLHD).

At War Memorial Hospital we are adopting the principles enunciated by Uniting in their document, *Future Horizons*, which will guide Uniting over the next 10-year journey. This Clinical Strategic Plan outlines the way we will work towards these principles to enable us to build a greater positive impact for the community we serve.

The South Eastern Sydney Local Heath District's *Journey to Excellence Strategy 2018-2021* indicates that 82% of those over 85 years of age have a comorbidity. This document also highlights the need to provide patient centred care, based on their needs and experience, whilst focussing on building healthier communities where people live at home and spend less time in hospital beds.

The *War Memorial Hospital Waverley Clinical Strategic Plan 2018* seeks to transform and develop initiatives that keep patients and their family as active as possible. To this end, through a consultative planning workshop, inclusive of patients, family and other key stakeholders, we have identified seven key areas to augment or improve our current services. These areas are encapsulated within four pillars:

- Dynamic, person-centred and integrated care
- Family, carer and patient participation
- Community engagement and enduring partnerships
- Technology as an enabler of optimal outcomes.

As a service we are committed to excellence and quality care; adopting and moving with the needs of patients, their family and the local community.

In an ever changing environment, demands and emphasis must shift. WMH continues to care for older Australians, with early intervention and maintenance programs to promote independence at home and in the community.

I commend to you the War Memorial Hospital Waverley Clinical Strategic Plan 2018.

Gerard Hyde

Executive Manager
War Memorial Hospital, Waverley

WAR MEMORIAL HOSPITAL
WAVERLEY

STRATEGY ON A PAGE

Our Beliefs

We understand people's enduring desire to feel connected to society and to live with dignity, purpose and where possible, independence

We come from a belief that older people deserve the best possible care

We're for people who believe older age is to be celebrated - not ignored - and cherished - not endured

Our Purpose

We deliver a personalised ecosystem of health services for people over the age of 65, leading to better health and wellbeing outcomes

Our Vision

You're never too old to live life

PILLARS

DYNAMIC, PERSON CENTRED AND INTEGRATED CARE

Our flexible, agile approach means we give each and every patient individualised care and attention, and provide innovative programs that afford them the best chance of success

FAMILY, CARER & PATIENT PARTICIPATION

Pioneering and inspiring a holistic approach to the wellbeing of older people, we work in a proactive environment of inclusion and shared decision making

COMMUNITY ENGAGEMENT & ENDURING PARTNERSHIPS

Forging genuine and enduring partnerships within our community, all people will feel welcome and at ease to access our campus. Our campus is not only part of our community, it is recognised as a centre of excellence that is unsurpassed in NSW

TECHNOLOGY AS AN ENABLER OF OPTIMAL OUTCOMES

Upskilling our teams, patients and carers through partnering with experts in the field, we will embrace technology to optimise patient outcomes

Where do we come from?

We come from a belief that older people deserve the best possible care.

Our society and social norms inform our beliefs and expectations about ageing. Ageing is not seen as fashionable and discrimination occurs in work environments, in views about home ownership and even pension and health care entitlements. This is set against a backdrop of a society which values youth. These converge to reduce understanding, tolerance and fairness.

In 1922 we started delivering healthcare at War Memorial Hospital. Since 1985 we have focussed on older adults greater than 60 years of age, supporting people to live healthily into older age, and to continue to enjoy the life they want to live.

What do we aspire to?

Our vision is that **"You're never too old to live life".**

We understand people's enduring desire to feel connected to society and to live with dignity, purpose and where possible, independence. We believe in people living in their own home and community for as long as possible. We see ourselves as an enabler of wellbeing; helping people to help themselves. Our experience and studies confirm that connectedness to community and a sense of personal value creates fulfilment and positivity.

Our flexible, agile approach means we give each and every patient individualised care and attention, and a program that affords them the best chance of success.

We take both a proactive and reactive approach to care, depending on the circumstances of the person. This is only possible through teamwork and the quality of our suite of multidisciplinary services that we have meticulously developed over the past 95 years.

Importantly, we're for people who believe older age is to be celebrated, not ignored and cherished, not endured.

To inspire people, enliven communities and confront injustice

Who governs us?

We strive to provide health care services responsive to the needs of the aged and wider community and to maintain and enhance the quality of life in accordance with the spiritual values espoused by the Uniting Church in Australia through Uniting and the South East Sydney Local Health District (SESLHD) values. WMH has a shared governance with these two key organisations.

Uniting

WMH is the only hospital service governed by Uniting, which is one of the largest not-for-profit community service providers in NSW and the ACT with over 100 years of experience. Uniting provides a range of services including aged care and disability, community services, and chaplaincy and get involved in social justice and advocacy issues that impact on the people they serve. A focus at Uniting is taking real steps to make the world a better place, working to inspire people, enliven communities and confront injustice. As an organisation, Uniting celebrates diversity and welcomes all people regardless of lifestyle choices, ethnicity, faith, sexual orientation and gender identity. Uniting is a community services ministry of the Uniting Church.

Uniting 'Future Horizons' principles

Adopting the principles as enunciated by Uniting in Future Horizons will ensure we make a positive impact for people and the communities with the greatest need. This will be realised by our values: we are compassionate, respectful, bold and imaginative.

The seven principles are summarised in Table 1.

Table 1. 'Future Horizons' Principles and Description

Principles	Description – What this means at WMH
Pre-emptive action	We will work to intervene early to maintain independence for our older patients and carers
Whole of person/family & community approaches	We work across existing government and community providers to ensure the needs of our patients and family are met
More than Uniting	We will work to engage communities by being culturally sensitive and collaborative with others
Innovative, evidence-based & iterative approaches	We will try innovative approaches to practice and ensure our methods are based on evidence
Rigorous & holistic outcomes measurement	We will understand and articulate how our actions assist to improve outcomes
Responsible Stewardship	We will be responsible stewards of the assets and people we deliver care to and ensure prudent financial and risk management
Alignment and service focus	We will advocate on behalf of our patients and families to enable the best services and community care for them

South Eastern Sydney Local Health District

WMH is an affiliated hospital with the South East Sydney Local Health District (SESLHD).

SESLHD is undertaking a process of transformation radically changing the healthcare landscape across the District extending from Sydney's eastern suburbs and Sydney's Central Business District through to the Royal National Park in the South.

With its vision being "Exceptional care, healthier lives", SESLHD sees its purpose "to enable our community to be healthy and well; and to provide the best possible compassionate care when people need it". SESLHD's Journey to Excellence strategy focuses on safe, person-centred and integrated care; workforce wellbeing; better value; community wellbeing and health equity; fostering research and innovation. These are underpinned by partnerships that deliver; responsive information management systems; data and analytics, fit for purpose infrastructure and a culture of continuous improvement.

Who are our community?

In 2016, approximately 396,000 people lived in the northern part of SESLHD. The 70-84 years age group is expected to be the fasting growing age group to 2031, followed by people aged 85 years.

As the total number of older people increases, so will the number of frail older people. Quantifying the total number of frail older people is problematic, and different degrees of frailty will require different supportive services and interventions.

Advancing age comes with comorbidities especially frailty and an increasing likelihood of dementia. Dementia now affects almost 1 in 10 (8.8%) people aged 65 and over in Australia, with people aged 85 and over accounting for 43% of cases.[1] In the absence of effective prevention or cure options, the Australian Institute of Health and Welfare projects that between 2010 and 2050, the number of people with dementia will treble with 29.5% of people 85+ experiencing dementia. Over 1,000 hospitalisations were recorded in 2016/17 for Northern SESLHD residents aged 65 and over with dementia as a principal diagnosis or as a comorbidity, with more than 50% of these people aged 85 or over.[2]

The people we see are at high risk of falling. Age-standardised rates of hospitalised fall injury cases in Australia increased over the period 2002–03 to 2014–15 for both men (3% per year) and women (2%), with almost 3% of hospitalisations for people aged 65 and over the result of a fall. Injuries to the hip and thigh (24%) and head (24%) were the most common types of injury resulting from a fall. The average total length of stay per fall injury case is estimated to be 13 days. Overall, 1 in every 10 days spent in hospital by a person aged 65 and over in 2014–15 was attributable to an injurious fall.[3]

Over 3,700 falls related hospitalisations were recorded for Northern SESLHD residents from 2015/16 to 2016/17.[4]

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[1] Australian Institute of Health and Welfare 2016. Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW. URL: https://www.aihw.gov.au/getmedia/9844cefb-7745-4dd8-9ee2-f4d1c3d6a727/19787-AH16.pdf.aspx?inline=true

[2] HealthStats NSW. Dementia hospitalisations as a principal diagnosis or as a comorbidity, SESLHD 2012/13-2015/16, persons aged 65 and over, by LGA. URL: http://www.healthstats.nsw.gov.au/Indicator/bod_dementhos/bod_dementhos_lgamap

[3] AIHW: Pointer S 2018. Trends in hospitalised injury due to falls in older people, 2002–03 to 2014–15. Injury research and statistics series no. 111. Cat. no. INJCAT 191. Canberra: AIHW. URL: https://www.aihw.gov.au/getmedia/39e62afd-7207-460d-aaa6-4f0c95ae665a/aihwinjcat-191.pdf.aspx?inline=true

[4] HealthStats NSW. Fall-related injury hospitalisations by Local Government Area, persons of all ages, NSW 2015-16 to 2016-17 URL: http://www.healthstats.nsw.gov.au/Indicator/inj_falloldhos/inj_falloldhos_lgamap?&topic=Falls&topic1=topic_inj&code=inj_fall

What do we do?

Our primary role is rehabilitation and assessment services for people aged over 60 years. We provide 24 hour inpatient rehabilitation, Day Rehabilitation and Monday to Friday outpatient clinics. The hospital has multiple specialist community teams inclusive of our community and Residential Aged Care Facility Geriatric Flying Squad (rapid response multidisciplinary), Young Onset Dementia Service (YODs), Transitional Aged Care (both community and residential care), Aged Care Assessment Team (ACAT), a 7 day per week Day Centre, a Seniors' Gym and Elizabeth Hunter Lodge which is our 24 hour accommodation service for regional/rural guests. A full range of hospital support services complements our health services.

We provide a number of specialist clinics and health promotion activities including:

- Specialist Geriatric assessment
- Frailty intervention and reconditioning
- Progressive neurological disorders
- Falls management
- Comprehensive Allied Health services
- Hydrotherapy
- Specialised individual and group therapies
- Health Promotion seminars.

The Hospital campus also accommodates the Northern Network Access and Referral Centre, Prince Of Wales Hospital (POWH) Home Dialysis services, Dementia Australia NSW (formerly Alzheimer's Australia NSW and Parkinson's NSW Counselling Services.

Non-Admitted Patient Services

There are a suite of non-admitted services at WMH that provide interventions tailored to a client's individual needs and complexities. There are specialised single discipline therapies providing aged care rehabilitation and multidisciplinary services delivering a range of services that continue to be in demand across the service sector and the community including, but not limited to:

- Transitional Aged Care
- Hydrotherapy
- Geriatric Flying Squad
- Day Centre.

In line with community needs, there has recently been a shift towards providing boutique services including anticipatory multidisciplinary care to clients with more complex needs. This is reflected in the service development of the iREAP program, Younger Onset Dementia (YODs)service and the primary progressive aphasia (PPA) and related disorders clinic.

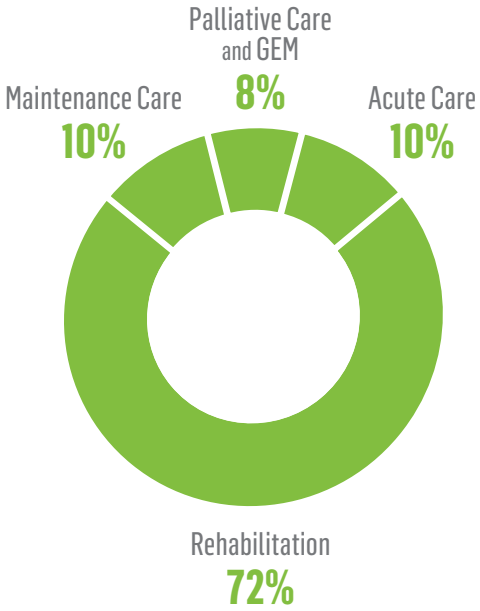
There has also been a focus within outpatients on integrated care which works with consumer and community providers to improve the patient journey.

We deliver a personalised ecosystem of health services for people over the age of 60, leading to better patient outcomes

Inpatient Services

WMH has 35 inpatient beds. Patients are pre-dominantly admitted as rehabilitation but with changes in patient's health status, ageing of the community and increasing emphasis on ensuring the appropriate care type, this has decreased over the years. In 2011-2012 91% of all admitted patients were rehabilitation compared to 72% in 2016-2017 (Figure 1).

Figure 1 Percentage of all Admitted Care Types in 2016/2017



This has been matched by an increase in Maintenance Care (from 6% to 10%) and a significant increase in acute care types from 3% to 10%. Geriatric Evaluation Management (GEM) care types have increased from less than 1% to 10% over the past 5 years. This reflects the increasing frailty and complexity of the inpatient cohort. According to Australasian Rehabilitation Outcomes Centre (AROC), 88% of rehabilitation patients at WMH have at least one comorbidity compared to rehabilitation patients across the rest of Australia at 51%.

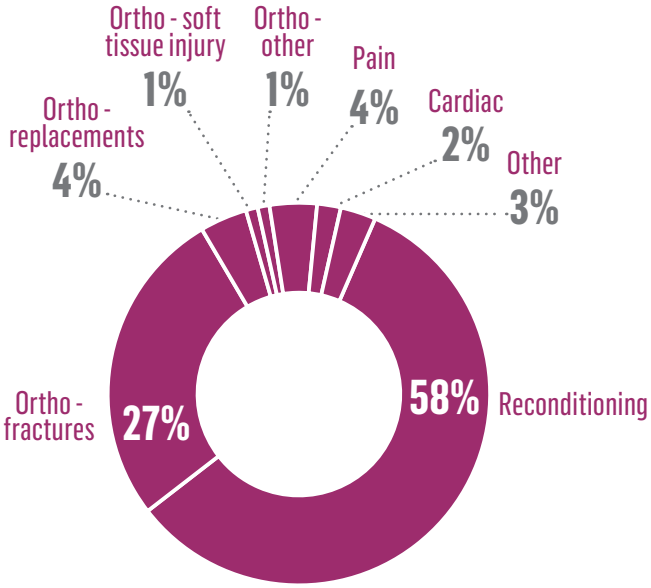
Age of Rehabilitation Patients

The average age of rehabilitation patients at WMH is 84.2 years old compared to rehabilitation patients across Australia which is 74.2 years old. This means our patients are on average 10 years older. This trend has been unchanged over the past decade.

Rehabilitation Impairment Types

58% of episodes at WMH are reconditioning, followed by orthopaedic fractures at 27%, and pain at 4% (Figure 2). This has been WMH's patient mix over the past decade.

Figure 2 Breakdown of Impairment types



(Source: from AROC Facility Report for WMH 2016/17)

What makes us different?

We are small and personal with an old world feel but a contemporary approach.

Since our transition to a subacute aged rehabilitation hospital in 1985, WMH has had a strong focus on finding innovative ways to deliver superior outcomes for patients.

We are experts at handling challenging health care and social needs of older people, with a diverse suite of comprehensive services and programs.

The care I was given made it feel like a second home

April 2018 (inpatient)

The exceptional care and support from all levels of people working here.

April 2018 (inpatient)

Every member of staff, nursing, therapists, dining room, cleaning have been so professional and encouraging

April 2018 (inpatient)

The programme has addressed all of the health and social issues that are of vital importance to me as I have aged. Moreover, I've been guided to and educated about significant concerns of which I had only been minimally aware

Jan 2018 (iREAP patient)

What is our partnership approach to care?

Patients, Carers and our Community

A critical dimension to our facility has been patient/carer engagement and involvement to enable meaningful and effective services. In line with current evidence[5] we are moving away from doing for, to working with our patients/carers. This means partnering with patients/carers as co-producers and co-designers for clinical service provision. Co-production shifts the power dynamic between the service provider and the patients, families and carers, placing equal value on professional training and lived experience.

This emergent approach has begun to take traction as evidenced by a higher level of patient/carer involvement in the following:

- Development of patient information flipchart
- Funding application and modelling of the iREAP Service
- Patient and carer presentations and participation at the Clinical Strategic Planning Day 2017
- WMH representative at the newly formed SESLHD District Consumer and Community Council (DCCC[6]).

To complement this shift, there has also been greater patient/ carer participation in local quality initiatives such as the development and design of a therapeutic garden and active involvement with the Fitness and Wellness Beyond the Hospital (FITWE) clinical trial. FITWE is a volunteer supported program to assist people with the transition from hospital (inpatient and outpatient) to the community setting.

Other Partners

To optimise service provision at WMH we have strategically positioned ourselves in the community with partners that can enhance, promote or improve the needs of patients and carers.

WMH has fostered a strong relationship with other organisations, including the Central and Eastern Sydney Primary Health Network (CESPHN) and the Agency for Clinical Innovation (ACI), engaging through shared projects and regularly seeking advice and consultation in areas of service development and improvement. Furthermore, we have established a successful history in partnering with these organisations to develop new services including our unique day rehabilitation and enablement program (iREAP) and the afterhours Geriatric Flying squad expansion into residential aged care facilities. Both collaborations have seen improved patient outcomes and prevention of unnecessary hospital admissions.

There are a number of other key clinical partnerships for WMH including the Prince of Wales Hospital and Sydney Hospital operated by SESLHD and the St Vincent's Hospital Network.

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[5] Batalden, M et al (2015). Coproduction of healthcare service, BMJ http://qualitysafety.bmj.com/content/qhc/early/2015/09/16/bmjqs-2015-004315.full.pdf
Improving quality and safety through partnerships with patients and consumers
https://www.safetyandquality.gov.au/wp-content/uploads/2012/03/PCC_Paper_August.pdf

[6] DCCC - This is a newly formed SESLHD Committee for consumers and community members to help improve the way we do our work by working together as co-producers and co-designers of care. Studies have shown if we listen to patient/carers/community groups it results in less deaths, less people coming back into hospital soon after they were discharged, less healthcare acquired infections, people getting home from hospital sooner and people having better health overall.

What have we achieved?

Key achievements of the previous Clinical Services Strategic Plan 2015-2018 include:

Inpatient Model of Care

The Inpatient Model of Care Project shifted its focus from a clinician's perception (modelling) towards enhancing the journey from the patient's perspective to become the Patient Experience Project (PEP). The key outcome is a clearly defined approach towards a positive patient experience. This means that care will be driven less on our needs but more about an equal partnership with patient/ carers. The PEP (Stage 1) resulted in a number of key recommendations to facilitate this approach for each step of the patient journey.

Volunteer Program

A structured volunteer program was developed that specifically targeted healthy and active ageing through better training and utilisation of volunteers across the facility. This was achieved through partnering with volunteers and staff to help create a supportive and encouraging environment for existing and potential volunteers. Key outcomes for volunteers meant they had support and supervision and involvement in a broader range of volunteer activities. All volunteers receive training to ensure they carry out their roles safely, efficiently and effectively. Volunteers now have a dedicated volunteers' room with locker and kitchen facilities.

Expert Aged and Rehabilitation Education

An Inter-professional Education Generation Group (IPEGG) was established to provide a meaningful multidisciplinary education program. This program is sustainable through the ongoing work of IPEGG who ensure the continued professional and workplace development of all WMH staff. Staff now have access to a more diverse and multidisciplinary educational program.

> **Dad usually just sits around at home so this has really motivated him to get better**
>
> **GC (Carer) - Jan 2018 iREAP**

Day Rehabilitation Program: iREAP

iREAP is an innovative redesign of the traditional Day Rehabilitation Model with a focus on pre-crisis early intervention and partnerships with primary care (through CESPHN) to identify patients in the community.

iREAP addresses the need to provide proactive coordinated and integrated, semi-intensive, multidisciplinary rehabilitation to specific patient groups in an outpatient setting.

Through an eight week evidence based program, iREAP has achieved:

- Improved physical function, quality of life and reduced frailty
- Timely, efficient and effective care to reduce hospital admissions
- Improved patient experience and self-management.

Statistically significant improvements were shown for the following outcomes from an evaluation of 99 patients from March 2016 until December 2017:

- Improved function and confidence to self-manage (mean pre and post Timed Up and Go 16.99 to 14.24 seconds ($p = 0.007$); Falls Efficacy Scale reduction 33 to 29 ($p<0.001$))
- Mean pre and post Clinical Frailty Scale reduced from 4.93 to 3.76 ($p = 0.05$)
- Six minute walk test (MWT) 293.81 metres to 336.05 metres ($p=0.001$)
- Improvement in quality of life as shown on World Health Organisation Quality of Life scale increased from 78 to 82 ($p=0.035$) and Parkinson's Disease Questionnaire-39 (PDQ-39) reduced from 49 to 39 ($p = 0.001$).

Patient experience feedback highlights iREAP as a model which is embraced and highly valued by the clients who participate in it.

Primary Progressive Aphasia and Related Disorders Clinic

The primary progressive aphasia (PPA) and related disorders clinic was established to provide comprehensive speech pathology services, with the future goal of integrated speech pathology, medical and psychological services for people with PPA and related disorders and their families.

The key patient care achievements include:

- Specialist speech and language assessment
- Individualised evidence based behavioural interventions such as word retrieval treatment
- Alternative and augmentative communication
- Dysphagia management
- Outreach and provision of resources to regional and rural services
- Enhancing success in conversation with conversation partner training
- Education and support - individual and groups. Collaboration with clinical psychology
- 36 new patients assessed 2015-2016.

Staff have represented the primary progressive aphasia (PPA) and related disorders clinic for Uniting and WMH at a range of local and international events and conferences. There has also been authorship, involvement and contribution to a number of research projects and publications.

Other notable achievements

Enhanced Geriatric Flying Squad

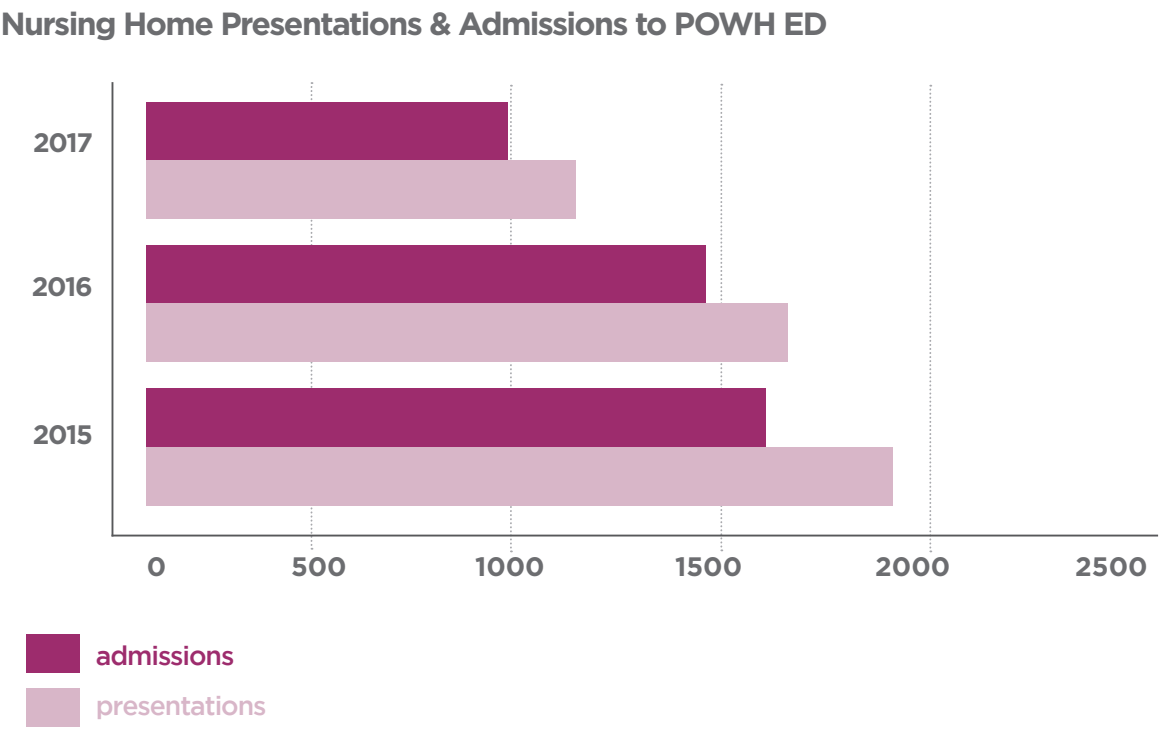
The Geriatric Flying Squad (GFS) is a rapid response multi-disciplinary team who provide comprehensive geriatric assessment and a case coordination service for older people living in the community or a residential aged care facility (RACF) and who are suffering from a subacute physical, functional or cognitive decline. The primary goal is to improve quality of care in partnership with older people.

In May 2017, the Central and Eastern Sydney Primary Health Network provided the funding for Nurse Practitioner/Transitional Nurse Practitioner and a Geriatrician to allow the GFS to expand its service to provide a more rapid response and after-hours cover to RACFs on evenings, weekends and public holidays. Residents who are experiencing an acute deterioration and for whom a hospital transfer is being considered can now be reviewed. Assessment, diagnosis, treatment and supportive interventions can be managed within the familiarity and comfort of the RACF, thereby reducing transfer and admission to hospital and preventing disruptions in care and complications.

Since expanding the service in May 2017, the GFS has seen 284 clients. Recent data analysis for RACF residents presenting to the Emergency Department at POWH showed a significant reduction since the expanded service commenced, compared to the same period in 2015-2016 (Figure 3).

Data comparisons over the winter months (June-August) from the 2015 calendar year to the 2017 calendar year indicate a reduction of presentations by 55% and a reduction of admissions by 53% from RACF residents. Thus, the contribution made by GFS helps to reduce the additional demands placed on POWH during winter and translates overall to better outcomes for older people in residential care and less pressure on our emergency departments.

Figure 3: Nursing Home Presentations and Admissions to ED from 2015-2017 Calendar Years



Aged Care Assessment Team

Amalgamated ACAT

Waverley ACAT has been one of the four ACAT hubs across the SESLHD that have amalgamated into one SESLHD ACAT under the governance of SESLHD Aged Care Assessment Programme Manager and Primary Integrated Health Unit. The challenge has been to transition all four teams into one streamlined approach and set of business rules, in addition to its new relationship with the Centralised Intake Service (CIS). Waverley has a long and proud history of delivering high quality aged care assessment services to the populations of the eastern suburbs of the Sydney community. This has continued through the period of amalgamation and centralised intake.

Centralised Intake Service

The Centralised Intake Service (CIS) was formed in July 2016, with WMH successful in its submission for tender to centralise the intake of all ACAT referrals across SESLHD. WMH operates the CIS on behalf of SESLHD ACAT services. This has also become a front line enquiry for the navigation of My Aged Care. The new workforce of CIS administrative staff undertake the Intake as well as the Scheduling of all ACAT appointments for the 4 local ACAT hubs including Waverley, Randwick, Kogarah and Sutherland. With the delivery of ACAT services being under increased scrutiny and KPIs from Commonwealth, State and LHD level, CIS has been instrumental in refining the centralised services to ensure consistency across what were previously four very separate ACAT sites and unique business processes. Now that the CIS processes are embedded, the management of the CIS will revert to central SESLHD management.

How do we turn our vision into action?

We are pioneering and inspiring a holistic approach to the wellbeing of older people. We create an environment where all patients and carers feel welcome and at ease, and are truly partners in care and service planning. We are proactive in reducing the impact of frailty and dementia, throughout our services, and routinely use health coaching techniques.

The quality of our multidisciplinary team; our partnerships; our commitment to research and evaluation; the connectedness of our inpatient and outpatient services and our unique rehabilitation campus contribute to us being a centre of excellence.

We have identified seven areas where additional effort is required to augment or improve:

- Coordination of Dementia Services
- Older Drivers
- Outdoor Gym & Physical Activity
- Foster links with the young people and general community
- Patient Experience Project (Stage 2)
- Sustainable research culture
- Developing technology as a health tool.

These are shown in relation to the pillars (Figure 4) and in the following implementation plan, recognising that some activities impact on more than one priority.

Figure 4: Priority Areas for Action

PILLARS	1. Dynamic, Person Centred and Integrated Care	2. Family, Carer and Patient Participation	3. Community Engagement and Enduring Partnerships	4. Technology as an Enabler of Optimal Outcomes
KEY INITIATIVES	**Coordination of Dementia Services**			
	Older drivers		**Older drivers**	
	Outdoor gym and physical activity			
			Foster links with young people and general community	
	Patient Experience Project (Stage 2)			
				Sustainable research culture
			Developing technology as a health tool	

Implementation Plan

Pillar	SESLHD*	Activity	Outcomes	Activity Lead	Activity Shared	Start date	End date
1, 2	1, 4	**Coordination of Dementia Services** **Actions:** Develop a WMH Dementia Interest Group (DIG) - Staff who dig Dementia! who will: • Document current services and investigate gaps • Investigate methods to coordinate services e.g Dementia Coordinator Role, Dementia Hub, etc • Develop a Dementia Plan that considers the following: – Information and education for patients, carers, staff and community – Ways to better access services especially after hours – Promotion of Dementia services at WMH e.g family open day – Developing a skilled workforce in Dementia care – Connecting patients and carers to resources on websites – Partnerships with relevant groups e.g Dementia Australia	Dementia Services are strengthened and enhanced across WMH: • Services are focussed on reducing patient and carer stress • Reduced impact of frailty • Improved access especially to after-hours service • Improved community perception of Dementia • WMH recognised as a service of excellence for Dementia • Evidence of projects, outcomes and publications from collaboration with partners	Allied Health & Integrated Care Manager	GPs, CESPHN, Dementia Australia	Jul 2018	Jun 2020
1, 3	1, 4	**Older Drivers** **Action:** Partner with a driving school to provide a pre-emptive approach for patients to have access to driver education	• All patients have access to driving assessments • Safe competent drivers enabled to maintain independence • Alternative transport options are considered by patients	Occupational Therapy Manager/ Director Medical Services	Private driving schools	Aug 2018	Dec 2019

* SESLHD codes relate to Strategic Priorities from the SESLHD Journey to Excellence – see Appendix for coding key.

Pillar	SESLHD*	Activity	Outcomes	Activity Lead	Activity Shared	Start date	End date
1,2	1,4	**Outdoor gym and physical activity** **Actions:** • Explore and research design options of outdoors space for rehabilitation and exercise • Broad consultation with internal and external advisers, including patients and carers and the Healthy Aging Gym • Prepare a business case • Approval from Council • Seek sponsorship from potential partners	• Provision of an outdoor gym on site for patients, carers and staff • Increased levels of physical activity • Reduced frailty • More self-directed activity	Physiotherapy Manager / Executive Manager	Healthy Aging Gym; private sponsors	Jul 2018	Dec 2019
2	1	**Patient Experience Project** **Action:** • Implement Stage 2 of the Patient Experience Project (PEP)	• A coordinated MDT process for inpatient admission, gathering of essential information and daily patient tasks • Structured Interdisciplinary Bedside Rounds (SIBR) is trialled to enable collaborative goal setting and review throughout the patient stay • Clear communication between the patient/ carer and the team through the introduction of a communication board • A smooth, time-efficient transition for patients/carers from WMH to a RACF • Improved patients/carers' transition from discharge to home • Improved access to alternative transport options • Patients safer at home in the immediate post-discharge period • Options for meal provision in the initial phase of returning home • Independence and connection to community maintained • Improved patient flow for admissions and discharges	Nurse Unit Manager		Jul 2018	Jun 2021

Pillar	SESLHD*	Activity	Outcomes	Activity Lead	Activity Shared	Start date	End date
3,4	4	**Foster links with young people and the general local community** **Actions:** • Engage children and young people with older people: – Linkages with local schools – Use technology to connect children/young people with patients • Foster links and shared activity with the local community: – Presentations to groups eg Probus, Rotary, Seniors' Groups – Use of WMH facility by community based groups for meetings, outdoor gym and pool	• Increased social connectedness between children, young people and older people • Reduced social isolation of patients • Increased health literacy amongst local community groups • Broadened access to WMH facility • Service is promoted consistently in the local community	Social Work Manager Health Promotion Executive Manager OT		Jul 2018	Jun 2021
3,4	5	**Develop a sustainable research culture** **Actions:** • Working with the SESLHD and Uniting Research strategies • Increase the partnership with SESLHD and universities • Develop WMH capacity to initiate and accommodate research • Support staff to be involved in research and publication • Engage patients and carers in research design	• Increased numbers of staff involved in and leading research and publication • Co-design and consumer led research and evaluation • Increased evidence based practice for services and programs • Increased profile of WMH services and clinicians	Services Manager/ Staff Specialist	Universities, ACI	Jul 2018	Jun 2021

Pillar	SESLHD*	Activity	Outcomes	Activity Lead	Activity Shared	Start date	End date
4	4, E2	**Develop technology as a health tool** Actions: • Explore the potential use of technology to improve patient care and carer's health and wellbeing: – Innovative use of technology eg virtual reality relaxation tool, health monitoring – Develop a consumer/carer led service directory and site navigation – Engage children and young people as "teachers"	• Increased access to and use of technology by patients, eg virtual reality relaxation tool, health monitoring, wearables • Increased social connectedness between children, young people, volunteers and older people • Consumer led service directory and site navigation	Services Manager		Jul 2018	Jun 2021
	E2, E3	• Improve staff technological literacy and enhance access to technology – Increase knowledge of applications available – Skills in applications for clinical management – Continue to improve access to computers and hand-held devices	• Better use of technology to communicate over the WMH campus • Staff are more health technology aware • Increased utilisation of technology for clinical management and evaluation • Improved access to computers and hand-held devices				
	E2	• Form partnerships with technology companies and services	• Access to expert technical knowledge • Enhanced opportunities for technological solutions eg "Smart Ageing" and "Dementia Friendly" • WMH as a flagship hospital for technology product development				

Appendix

Planning Process

The development of this Plan was due to the contributions from many people.

This occurred through three key stages:

- Brand conviction workshop with the executive
- 1st Workshop- leadership group identified and confirmed planning approach and pillars
- 2nd Workshop- broader consultation with key stakeholders including patient and carer representatives, and representatives from Uniting, SESLHD, CESPHN, ACI and staff from WMH
- Consultation and progress review with the executive.

The Plan was prepared and written by:

- Fiona Russell, Clinical Performance Coordinator, War Memorial Hospital Waverley and
- Alison Sneddon, Senior Health Service Planner/Manager Strategy and Planning Unit, Directorate of Planning, Population Health and Equity (DPPHE), SESLHD.

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- Representatives from Uniting
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- SESLHD iiHub
- SESLHD Strategy and Planning Unit, DPPHE
- ACI
- Central and Eastern Sydney Primary Health Network
- Consumer and Carer Representatives
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- Mark Shepherd
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- Shona Dutton
- Bevan Wood
- Col Blake
- Peter Stanbury
- Ian Ward

SESLHD Journey to Excellence Strategy: Strategic Priorities

Coding in the Implementation Plan

Strategic Priorities	
1	Safe, person-centred and integrated care
2	Workforce wellbeing
3	Better value
4	Community wellbeing and health equity
5	Foster research and innovation
Enablers	
E1	Partnerships that deliver
E2	Responsive Information Management Systems
E3	Data & Analytics
E4	Fit for purpose infrastructure
E5	A culture of continuous improvement

WAR MEMORIAL HOSPITAL WAVERLEY

Uniting

NSW GOVERNMENT Health
South Eastern Sydney
Local Health District